COLORADO
Department of Health Care Policy & Financing

Regional Accountable Entities (RAEs)
for the Colorado Accountable Care Collaborative

Fiscal Year 2021–2022 PIP Validation Report

for

Colorado Community Health Alliance Region 6

April 2022

This report was produced by Health Services Advisory Group, Inc. for the Colorado Department of Health Care Policy & Financing.

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

The Code of Federal Regulations at 42 CFR Part 438—managed care regulations for the Medicaid program and Children's Health Insurance Program (CHIP), with revisions released May 6, 2016, effective July 1, 2017, and further revised on November 13, 2020, with an effective date of December 14, 2020—require states that contract with managed care health plans (health plans) to conduct an external quality review (EQR) of each contracting health plan. Health plans include managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), primary care case management entities (PCCM entities), and prepaid ambulatory health plans (PAHPs). The regulations at 42 CFR §438.350 require that the EQR include analysis and evaluation by an external quality review organization (EQRO) of aggregated information related to healthcare quality, timeliness, and access. Health Services Advisory Group, Inc. (HSAG), serves as the EQRO for the State of Colorado, Department of Health Care Policy and Financing (the Department)—the agency responsible for the overall administration and monitoring of Colorado's Medicaid program. Beginning in fiscal year (FY) 2018–2019, the Department entered into contracts with Regional Accountable Entities (RAEs) in seven regions throughout Colorado. Each Colorado RAE meets the federal definition of a PCCM entity.

Pursuant to 42 CFR §438.350, which requires states' Medicaid managed care programs to participate in EQR, the Department required its RAEs to conduct and submit performance improvement projects (PIPs) annually for validation by the State's EQRO. **Colorado Community Health Alliance Region 6**, referred to in this report as **CCHA R6**, holds a contract with the State of Colorado for provision of healthcare services for Health First Colorado, Colorado's Medicaid program.

For fiscal year (FY) 2021–2022, the Department required health plans to conduct PIPs in accordance with 42 CFR §438.330(b)(1). In accordance with §438.330 (d), MCOs, PIHPs, PAHPs, and PCCM entities are required to have a quality program that (1) includes ongoing PIPs designed to have a favorable effect on health outcomes and beneficiary satisfaction and (2) focuses on clinical and/or nonclinical areas that involve the following:

- Measuring performance using objective quality indicators
- Implementing system interventions to achieve quality improvement (QI)
- Evaluating effectiveness of the interventions
- Planning and initiating activities for increasing and sustaining improvement

As one of the mandatory EQR activities required by 42 CFR §438.358(b)(1)(i), HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services

(CMS) publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[1-1]

In July 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement.[1-2] The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous QI. The redesigned framework redirects MCOs to focus on small tests of change to determine which interventions have the greatest impact and can bring about real improvement. CMS agreed that given the pace of QI science development and the prolific use of Plan-Do-Study-Act (PDSA) cycles in modern improvement projects within healthcare settings, a new approach was needed and provided HSAG with approval to use this approach in all requesting states.

PIP Components and Process

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing a measure, determining interventions, testing interventions, and spreading successful changes. The core component of the approach involves testing changes on a small scale—using a series of PDSA cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies—so that improvement can occur more efficiently and lead to long-term sustainability. The duration of rapid-cycle PIPs is approximately 18 months, from the initial Module 1 submission date to the end of intervention testing.

There are four modules with an accompanying reference guide for the MCOs to use to document their PIPs. Prior to issuing each module, HSAG held module-specific trainings with the

PIP Terms

SMART (Specific, Measurable, Attainable, Relevant, Time-bound) Aim directly measures the PIP's outcome by answering the following: *How much improvement, to what, for whom, and by when?*

Key Driver Diagram is a tool used to conceptualize a shared vision of the theory of change in the system. It enables the MCO's team to focus on the influences in cause-and-effect relationships in complex systems.

FMEA (Failure Modes and Effects Analysis) is a systematic, proactive method for evaluating processes that helps to identify where and how a process is failing or might fail in the future. FMEA is useful to pinpoint specific steps most likely to affect the overall process, so that interventions may have the desired impact on PIP outcomes.

PDSA (Plan-Do-Study-Act) cycle follows a systematic series of steps for gaining knowledge about how to improve a process or an outcome.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 23, 2022.

[1-2] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: Feb 23, 2022.

MCOs to educate them about the documentation requirements and use of specific QI tools for each of the modules. The four modules are defined below:

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes building a PIP team, describing the PIP topic and narrowed focus, and providing the rationale and supporting data for the selected narrowed focus. In Module 1, the narrowed focus baseline data collection specifications and methodology are defined, and the MCO sets aims (Global and SMART), completes a key driver diagram, and sets up the SMART Aim run chart for objectively tracking progress toward improvement for the duration of the project.
- **Module 2—Intervention Determination:** In Module 2, there is increased focus on the QI activities reasonably expected to impact the SMART Aim. The MCO updates the key driver diagram from Module 1 after completing process mapping, failure modes and effects analysis (FMEA), and failure mode priority ranking, for a more in-depth understanding of the improvement strategies that are most likely to support achievement of the SMART Aim goal.
- **Module 3—Intervention Testing:** In Module 3, the MCO defines the intervention plan for the intervention to be tested, and the intervention effectiveness measure and data collection process are defined. The MCO will test interventions using thoughtful incremental PDSA cycles and complete PDSA worksheets.
- **Module 4—PIP Conclusions:** In Module 4, the MCO summarizes key findings, compares successful and unsuccessful interventions, and reports outcomes achieved. The MCO will synthesize data collection results, information gathered, and lessons learned to document the impact of the PIP and to consider how demonstrated improvement can be shared and used as a foundation for further improvement after the project ends.

Approach to Validation

The goal of HSAG's PIP validation and scoring methodology is to ensure that the Department and key stakeholders can have confidence that the health plan executed a methodologically sound improvement project, and any reported improvement can be reasonably linked to the QI strategies and activities conducted by the health plan during the PIP. HSAG obtained the data needed to conduct the PIP validation from **CCHA R6**'s module submission forms. In FY 2021–2022, these forms provided detailed information about **CCHA R6**'s PIP and the activities completed in Module 2 and Module 3. (See Appendix A. Module Submission Forms.) Following HSAG's rapid-cycle PIP process, the health plan submits each module according to the approved timeline. Following the initial validation of each module, HSAG provides feedback in the validation tools. If validation criteria are not achieved, the health plan has the opportunity to seek technical assistance from HSAG. The health plan resubmits the modules until all validation criteria are met. This process ensures that the PIP methodology is sound prior to the health plan progressing to intervention testing.

Validation Scoring

During validation, HSAG determines if criteria for each module are *Met.* Any validation criteria not applicable (*N/A*) were not scored. At the completion of Module 4, HSAG uses the validation findings from modules 1 through 4 to determine a level of confidence representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG will assign a level of confidence.

- ***High confidence*** = The PIP was methodologically sound; the SMART Aim goals, statistically significant, clinically significant, or programmatically significant improvements were achieved for both measures; at least one tested intervention for each measure could reasonably result in the demonstrated improvement; and the MCO accurately summarized the key findings and conclusions.
- ***Moderate confidence*** = The PIP was methodologically sound, at least one tested intervention could reasonably result in the demonstrated improvement, and at least one of the following occurred:

  ☐ The SMART Aim goal, statistically significant, clinically significant, or programmatically significant improvement was achieved *for only one measure*, and the MCO accurately summarized the key findings and conclusions.

  ☐ Non-statistically significant improvement in the SMART Aim measure was achieved *for at least one measure*, and the MCO accurately summarized the key findings and conclusions.

  ☐ The SMART Aim goal, statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement was achieved *for at least one measure*; however, the MCO *did not* accurately summarize the key findings and conclusions.

- ***Low confidence*** = One of the following occurred:

  ☐ The PIP was methodologically sound. However, no improvement was achieved for either measure during the PIP. The SMART Aim goals *were not* met, statistically significant improvement *was not* demonstrated, non-statistically significant improvement *was not* demonstrated, significant clinical improvement *was not* demonstrated, and significant programmatic improvement *was not* demonstrated.

  ☐ The PIP was methodologically sound. The SMART Aim goal, statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement was achieved *for at least one measure*; however, *none* of the tested interventions could reasonably result in the demonstrated improvement.

  ☐ The rolling 12-month data collection methodology was followed for only one of two SMART Aim measures for the duration of the PIP.

- ***No confidence*** = The SMART Aim measure methodology and/or approved rapid-cycle PIP methodology/process *was not* followed through the SMART Aim end date.

PIP Topic Selection

In FY 2021–2022, **CCHA R6** submitted the following PIP topic for validation: *Depression Screening and Follow-Up After a Positive Depression Screen*.

CCHA R6 defined a Global Aim and SMART Aim for the PIP. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. HSAG provided the following parameters to the health plan for establishing the SMART Aim for the PIP:

- **S**pecific: The goal of the project: What is to be accomplished? Who will be involved or affected? Where will it take place?
- **M**easurable: The indicator to measure the goal: What measure will be used? What current data (i.e., count, percent, or rate) are available for that measure? How much increase or decrease in the indicator will demonstrate improvement?
- **A**ttainable: Rationale for setting the goal: Is the desired achievement based on a particular best practice/average score/benchmark? Is the goal attainable (not too low or too high)?
- **R**elevant: The goal addresses the problem to be improved.
- **T**ime-bound: The timeline for achieving the goal.

Table 1-1 includes the SMART Aim statements established by **CCHA R6**.

Table 1-1—SMART Aim Statements

PIP Measures	SMART Aim Statements
Depression Screening	By June 30, 2022, use key driver diagram interventions to increase the percentage of depression screenings provided during an in-person or virtual outpatient primary care visit at Clinica Family Health among unduplicated CCHA members 12 years of age or older from 49.27% to 53.01%.*
Follow-Up After a Positive Depression Screen	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who receive an in-person or virtual qualifying behavioral health (BH) service by any BH provider on the day of or within 30 days from a positive depression screen administered during an outpatient primary care visit at Clinica Family Health among unduplicated CCHA members 12 years of age or older from 75% to 93.75%.*

* HSAG approved revisions to the SMART Aim statements in November 2021.

The focus of the PIP is to increase the percentage of members 12 years of age and older who receive a depression screening during a primary care visit at Clinica Family Health and to increase the percentage of those members who receive BH services within 30 days of screening positive for depression. In November 2021, **CCHA R6** communicated to HSAG the need to revise the initial SMART Aim statements and data collection methodology to better align with the improvement goals for the project. After a technical assistance discussion and receiving a written rationale from the health plan, HSAG

approved **CCHA R6** to revise the data collection methodology and SMART Aims. **CCHA R6** submitted updated Module 1 and Module 2 submission forms with revised documentation to HSAG on November 19, 2021. HSAG reviewed the revised data and confirmed that the goals to increase depression screening to 53.01 percent and to increase follow-up within 30 days after a positive depression screen to 93.75 percent represent statistically significant improvement over the revised baseline percentages.

Table 1-2 summarizes the progress **CCHA R6** has made in completing the four PIP modules.

Table 1-2—PIP Topic and Module Status

PIP Topic	Module	Status
Depression Screening and Follow-Up After a Positive Depression Screen	1. PIP Initiation	Completed and achieved all validation criteria.
	2. Intervention Determination	Completed and achieved all validation criteria.
	3. Intervention Testing	In progress. Module 3 submission forms submitted to date have achieved all validation criteria. The MCO will test interventions until June 30, 2022, and submit a new Module 3 submission form when a new intervention is initiated.
	4. PIP Conclusions	Targeted for October 2022.

At the time this FY 2021–2022 PIP validation report was produced, **CCHA R6** had passed Module 1 and Module 2, achieving all validation criteria for the PIP. **CCHA R6** had also passed all validation criteria for the Module 3 submission form submitted for each intervention being tested and was continuing to test interventions. The health plan will conclude all intervention testing on June 30, 2022. Module 4 validation findings will be reported in the FY 2022–2023 PIP validation report.

2. Findings

Validation Findings

In FY 2021–2022, **CCHA R6** continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan passed Module 2 and Module 3 of the rapid-cycle PIP process during FY 2021–2022. HSAG reviewed Module 2 and Module 3 submission forms and provided feedback and technical assistance to the health plan until all validation criteria were achieved. Below are summaries of the Module 2 and Module 3 validation findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. Detailed validation criteria, scores, and feedback from HSAG are provided in Appendix B. Module Validation Tools.

Module 2: Intervention Determination

The objective of Module 2 is to ask and answer the fundamental question, "What changes can we make that will result in improvement?" In this phase, **CCHA R6** developed process maps, conducted FMEAs, and updated key driver diagrams to identify potential interventions for the PIP. The detailed process maps, FMEA results, and updated key driver diagrams that **CCHA R6** documented in the Module 2 submission form are included in Appendix A. Module Submission Forms. Table 2-1 summarizes the FY 2021–2022 Module 2 validation findings for **CCHA R6**'s *Depression Screening and Follow-Up After a Positive Depression Screen* PIP.

Table 2-1—Module 2 Validation Findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

PIP Measures	Priority Failure Modes	Key Drivers	Potential Interventions
Depression Screening	• Minors are not screened for depression when mode of delivery is virtual • Member does not receive, fails to open, and/or does not fill out the screening tool • Staff does not administer a depression screen for members during primary care visit • Referral is generated but not "closed" or "completed" in the electronic health record (EHR)	• Provider engagement • Provider standards of care • Provider availability • Data accuracy and integration • Member access and engagement	• Provider education on screening completion and correct coding • Staff training to improve processes and address gaps • Address process for telehealth services • Improve appointment availability through same-day appointments, hours of operation • Accurate service coding and claims submission • Member transportation assistance • Increase member access to technology and Internet

PIP Measures	Priority Failure Modes	Key Drivers	Potential Interventions
Follow-Up After a Positive Depression Screen	• Referring providers do not verify and cannot ensure completion of referral process • Members' existing BH provider is not informed/aware of positive screen • Members with a positive depression screen are not referred for additional BH assessment/services	• Provider engagement • Provider standards of care • Provider availability • Data accuracy and integration • Member access and engagement	• Provider education on screening completion and correct coding • Staff training to improve processes and address gaps • Establish referral pathways for appropriate follow-up • Improve appointment availability through same-day appointments, hours of operation • Accurate service coding and claims submission • Member transportation assistance • Increase member access to technology and Internet

In Module 2, **CCHA R6** identified potential interventions that can reasonably be expected to support achievement of the SMART Aim goals by addressing priority failure modes and leveraging key drivers. The potential interventions **CCHA R6** identified to improve depression screening focused on provider and staff education, telehealth service availability, appropriate coding and billing practices, and addressing barriers to members accessing care. The potential interventions **CCHA R6** identified to improve follow-up services focused on provider and staff education, improved clinic workflow, appointment access and availability, and appropriate coding and billing practices.

Module 3: Intervention Testing

Module 3 initiates the intervention testing phase of the PIP process. During this phase, **CCHA R6** developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, **CCHA R6** submitted testing plans for two interventions. In addition to validating the intervention plans submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to provide support and technical assistance, if needed, as **CCHA R6** carried out PDSA cycles to evaluate intervention effectiveness. Table 2-2 presents the FY 2021–2022 Module 3 validation findings for **CCHA R6**'s two interventions.

Table 2-2—Module 3 Validation Findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Identify a virtual depression screening tool (PHQ-A)[1] for minors ages 12–17 years at Clinica Family Health, build an electronic PHQ-A form, and train Clinica staff to integrate the electronic screening tool into the virtual visit workflow	• Minors (ages 12–17 years) are not screened for depression when mode of delivery is virtual	• Provider Standards of Care: Adjust processes for remote services	• Percentage of members ages 12–17 years who attended a virtual outpatient primary care visit with Clinica and received a depression screening (G8431 or G8510) during the virtual visit
Develop a workflow for BH referral after a positive depression screen and train Clinica staff to consistently and successfully apply workflow to ensure members receive appropriate referral and follow-up	• Members with a positive depression screen are not referred for additional BH assessment and services	• Provider Standards of Care	• Percentage of members 12 years of age or older who had a positive depression screen at Clinica and who received a referral and BH service at Clinica within 30 days of the positive screen

[1]PHQ = Patient Health Questionnaire

In Module 3, **CCHA R6** selected two interventions to test for the PIP. The detailed intervention testing plans **CCHA R6** documented in the Module 3 submission forms are included in Appendix A. Module Submission Forms. The interventions addressed process gaps or failures in both virtual and in-person clinic workflows for depression screening and follow-up services. For each intervention, **CCHA R6** defined an intervention effectiveness measure to evaluate the impact of the intervention and provide data to guide intervention revisions. The health plan was continuing to test the interventions at the time this FY 2021–2022 PIP validation report was produced. **CCHA R6** will report final intervention testing results and conclusions as part of the Module 4 submission in FY 2022–2023, and the final Module 4 validation findings will be included in the FY 2022–2023 PIP report.

3. Conclusions and Recommendations

Conclusions

The validation findings suggest that **CCHA R6** successfully completed Module 2 of the rapid-cycle PIP process, using QI science-based tools to identify process gaps and failures, and to select PIP interventions. **CCHA R6** also passed Module 3 for two interventions, developing a methodologically sound plan for evaluating effectiveness of each intervention through PDSA cycles. **CCHA R6** will continue to test interventions for the PIP through the end of FY 2021–2022. The health plan will submit final intervention testing results, PIP outcomes, and project conclusions for validation in FY 2022–2023.

Recommendations

- **CCHA R6** should collect complete and accurate intervention effectiveness data for each tested intervention. The health plan should record intervention testing results and interpretation of results in the PDSA worksheet for each intervention, which will be submitted as part of Module 4—PIP Conclusions in FY 2022–2023.
- **CCHA R6** should ensure that the approved SMART Aim data collection methodology defined in Module 1 is used consistently to calculate SMART Aim measure results throughout the project. Using consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, **CCHA R6** should develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, **CCHA R6** should synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to documenting any improvement achieved through the project, the health plan should document which interventions had the greatest impact, including the evaluation data used to determine intervention effectiveness.

Appendix A. Module Submission Forms

Appendix A contains the Module Submission Forms provided by the health plan.

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Module 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 6

Managed Care Organization (MCO) Information	
MCO Name	Colorado Community Health Alliance (CCHA) Regional Accountable Entity, Region 6
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Contact Name	Kathryn Morrison
Contact Title	Medicaid Quality Management Health Plan Director
Email Address	kathryn.morrison2@anthem.com
Telephone Number	(719) 235-0384
Submission Date	4/14/2021
Resubmission Date (if applicable)	N/A
Revision Date	11/19/2021

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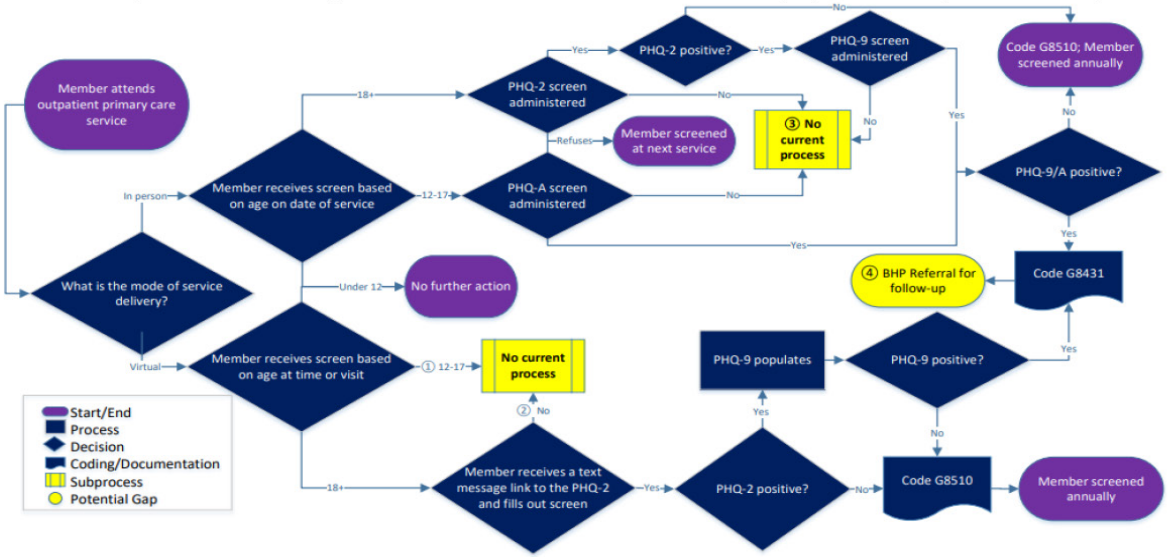
Process Map – *Depression Screening*

Instructions:

- Map the current process for members to receive ***Depression Screening*** at the narrowed focus level.
- Document each step of the process and highlight in yellow the steps within the process that have been identified as gaps or opportunities for improvement.
- Refer to Section 4 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* (Module 2—Intervention Determination) for information on how to complete a process map.

(Insert Process Map Here—Use an attachment or additional pages if more space is needed.)



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Failure Modes and Effects Analysis (FMEA) – *Depression Screening*

Instructions: In Table 1a, document the Failure Mode(s), Failure Cause(s), and Failure Effects(s) for the steps from the ***Depression Screening*** process map that were identified as a gap or opportunity for improvement.

- The steps in this table should be listed based on their potential for impacting the SMART Aim (i.e., the step having the greatest potential for impacting the SMART Aim should be listed first and the step having the lowest priority would be listed last.
- List at least two steps from the process map in the FMEA table.
- Use the same process map language for each step documented in the FMEA table.
- If multiple failure modes/causes/effects are entered for a step, use bullets to identify each one. Add additional rows to the table, if needed.
- Refer to Section 4 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* (Module 2—Intervention Determination) for information on how to complete the FMEA.

Table 1a—Failure Modes and Effects Analysis Table – *Depression Screening*

Steps from the Process Map	Failure Mode(s) (What could go wrong?)	Failure Cause(s) (Why would the failure happen?)	Failure Effect(s) (What are the consequences?)
① **No Current Process for virtual screening of members 12-17 years old**	Minors aren't screened for depression when mode of delivery is virtual.	• Electronic PHQ-A screening tool not available currently. • No process is in place to complete the screen in session.	Members 12-17 years old are not screened if service is provided virtually.

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② **No Current Process for remote screening of members who don't open link/fill out screen**	Member doesn't receive, fails to open and/or doesn't fill out the screening tool.	• Member doesn't receive text message with screening tool. • Member's contact information is not up to date. • Member refuses/forgets/doesn't see message in time for the session. • No process is in place to verify completion or to complete the screen in session.	Not all members 18+ years old are not screened if service is provided virtually.
③ **No Process to ensure staff consistently administer Depression screens (PHQ-2, PHQ-A and PHQ-9)**	Staff does not administer a Depression screen for members during a primary care visit.	• Staff training. • Staff misses/forgets to administer Depression screen at the time of service. • Staff prioritizes other needs/tasks and fails to administer depression screen at the time of service.	Eligible members may not receive a Depression screen at the time of service. Depression symptoms are not assessed, referrals to behavioral health services aren't provided, and members' Depressive Disorder may remain untreated.

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④ **BHP Referral for follow-up**	Referral is generated but not "closed" or "completed" in the EHR.	• Staff training. • Human error.	Referral process is not finished and referral for BHP follow-up is not sent out. BHP is not alerted of positive depression screen and members don't receive follow-up service.

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Failure Mode Priority Ranking – *Depression Screening*

Instructions: In Table 2a, list from highest- to lowest-priority at least two failure modes identified in the ***Depression Screening*** FMEA.

- The MCO should assign a numeric ranking to the failure modes from the highest-priority level (number one) to the lowest-priority level (last failure mode selected) based on FMEA results.
- The failure modes with the highest priority should take precedence when determining interventions to test.
- The MCO should rank the failure modes based on their potential to impact the SMART Aim rather than ranking failure modes based on which may be easiest to change.
- The highest-priority failure modes are those with the most leverage for impacting the SMART Aim.
- Use the same language for the listed failure mode that was used in the FMEA table.

Table 2a—Failure Mode Priority Ranking – *Depression Screening*

Priority Ranking	Failure Modes
1	**Minors aren't screened for depression when mode of delivery is virtual.**
2	**Member doesn't receive, fails to open and/or doesn't fill out the screening tool.**
3	**Staff does not administer a Depression screen for members during primary care visit.**
4	**Referral is generated but not "closed" or "completed" in the EHR.**

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Process Map – *Follow–up After a Positive Depression Screen*

Instructions:

- Map the current process for members to receive ***Follow–up After a Positive Depression Screen*** at the narrowed focus level.
- Document each step of the process and highlight in yellow the steps within the process that have been identified as gaps or opportunities for improvement.
- Refer to Section 4 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* (Module 2—Intervention Determination) for information on how to complete a process map.

(Insert Process Map Here—Use an attachment or additional pages if more space is needed.)

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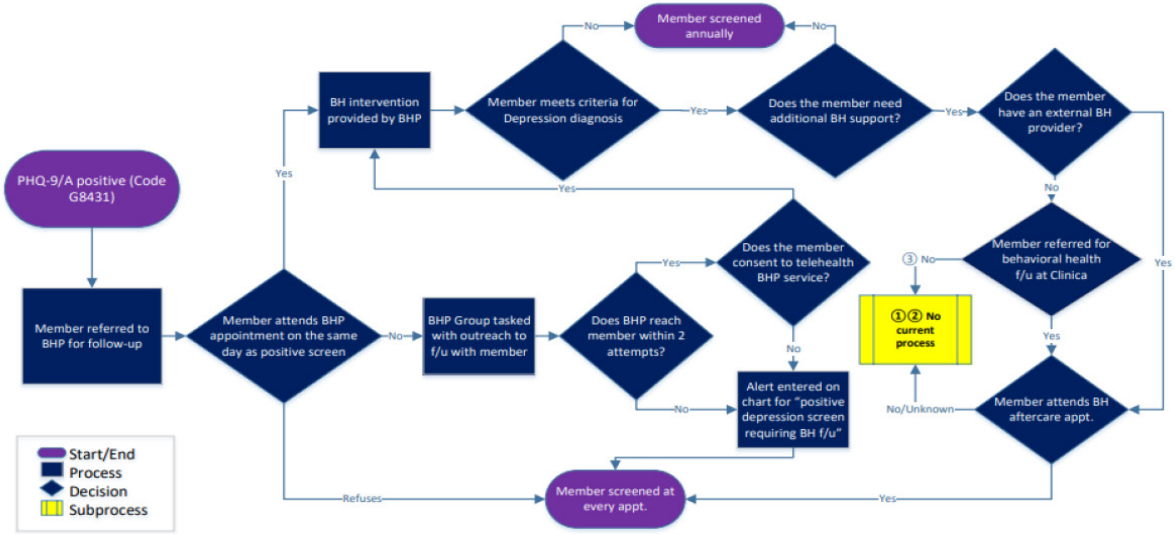

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Failure Modes and Effects Analysis (FMEA) – *Follow–up After a Positive Depression Screen*

Instructions: In Table 1b, document the Failure Mode(s), Failure Cause(s), and Failure Effects(s) for the steps from the ***Follow–up After a Positive Depression Screen*** process map that were identified as a gap or opportunity for improvement.

- The steps in this table should be listed based on their potential for impacting the SMART Aim (i.e., the step having the greatest potential for impacting the SMART Aim should be listed first and the step having the lowest priority would be listed last.
- List at least two steps from the process map in the FMEA table.
- Use the same process map language for each step documented in the FMEA table.
- If multiple failure modes/causes/effects are entered for a step, use bullets to identify each one. Add additional rows to the table, if needed.
- Refer to Section 4 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* (Module 2—Intervention Determination) for information on how to complete the FMEA.

Table 1b—Failure Modes and Effects Analysis Table – *Follow–up After a Positive Depression Screen*

Steps from the Process Map	Failure Mode(s) (What could go wrong?)	Failure Cause(s) (Why would the failure happen?)	Failure Effect(s) (What are the consequences?)
① **No Current Process to consistently verify if/when members attended external BH appointment**	Referring providers don't verify and cannot ensure completion of referral process.	• External Agency fails to inform referring provider of member's attendance/absence. • Referring provider fails to verify member's attendance with referral provider.	Referral may be unsuccessful, and member doesn't access/receive needed services.

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		• Member refuses to authorize care coordination between practices.	
② **No Current Process in place to inform members' existing BH providers of positive screen**	Members' existing behavioral health provider is not informed/aware of positive screen.	• No process is in place to inform ongoing providers of assessment scores/findings. • Member refuses to authorize care coordination between practices.	Members' provider does not take positive screen into account when providing treatment.
③ **No Current Process when a referral to BH services isn't provided.**	Members with a positive depression screen aren't referred for additional behavioral health assessment/services.	• Staff training. • Staff doesn't review the Depression screen to follow-up on positive result. • Staff misses/forgets to refer member to BH services.	Members' depression symptoms are not assessed further and Depressive Disorder may remain untreated.

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Failure Mode Priority Ranking – *Follow–up After a Positive Depression Screen*

Instructions: In Table 2b, list from highest- to lowest-priority at least two failure modes identified in the ***Follow–up After a Positive Depression Screen*** FMEA.

- The MCO should assign a numeric ranking to the failure modes from the highest-priority level (number one) to the lowest-priority level (last failure mode selected) based on FMEA results.
- The failure modes with the highest priority should take precedence when determining interventions to test.
- The MCO should rank the failure modes based on their potential to impact the SMART Aim rather than ranking failure modes based on which may be easiest to change.
- The highest-priority failure modes are those with the most leverage for impacting the SMART Aim.
- Use the same language for the listed failure mode that was used in the FMEA table.

Table 2b—Failure Mode Priority Ranking – *Follow–up After a Positive Depression Screen*

Priority Ranking	Failure Modes
1	**Referring providers don't verify and cannot ensure completion of referral process.**
2	**Members' existing behavioral health provider is not informed/aware of positive screen.**
3	**Members with a positive depression screen aren't referred for additional behavioral health assessment/services.**

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Key Driver Diagrams

Instructions: Update the ***Depression Screening*** and ***Follow–up After a Positive Depression Screen*** key driver diagrams from Module 1.

- At this stage of the PIP process, the MCO should use the findings from the process map, FMEA, and failure mode ranking to update drivers and interventions in each key driver diagram, as necessary. The MCO should ensure that the interventions are culturally and linguistically appropriate for the targeted population.
- Single interventions can address more than one key driver. Add additional arrows as needed.
- After passing Module 3 for each planned intervention and completing the testing of each intervention, the MCO should update the appropriate key driver diagram to reflect the status of each tested intervention (adapted, adopted, abandoned, or continue testing). The MCO should use the following color coding to distinguish the intervention status:
  - Green highlight for successful adopted interventions.
  - Yellow highlight for interventions that were adapted or not tested.
  - Red highlight for interventions that were abandoned.
  - Blue highlight for interventions that require continued testing.
- The finalized ***Depression Screening*** and ***Follow–up After a Positive Depression Screen*** key driver diagrams will be submitted at the end of the PIP with Module 4.

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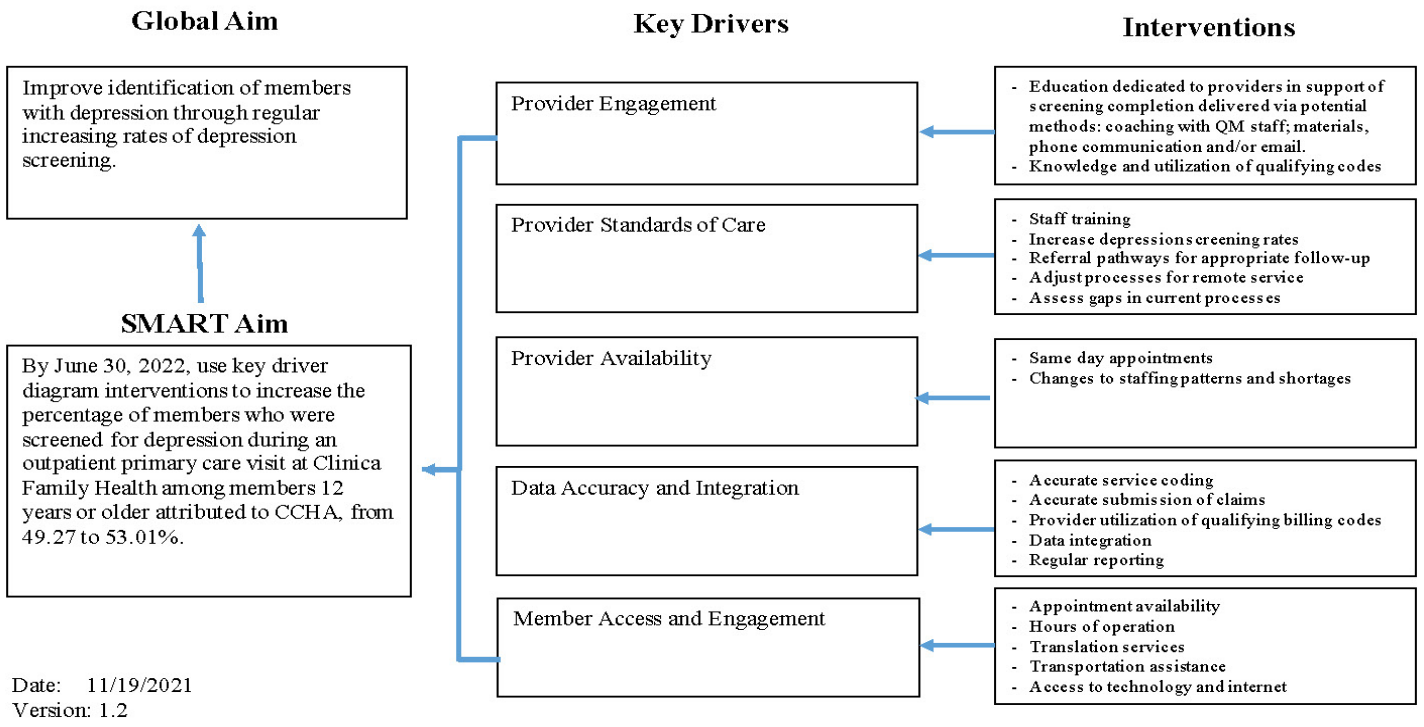
Key Driver Diagram– *Depression Screening*



Date: 11/19/2021
Version: 1.2

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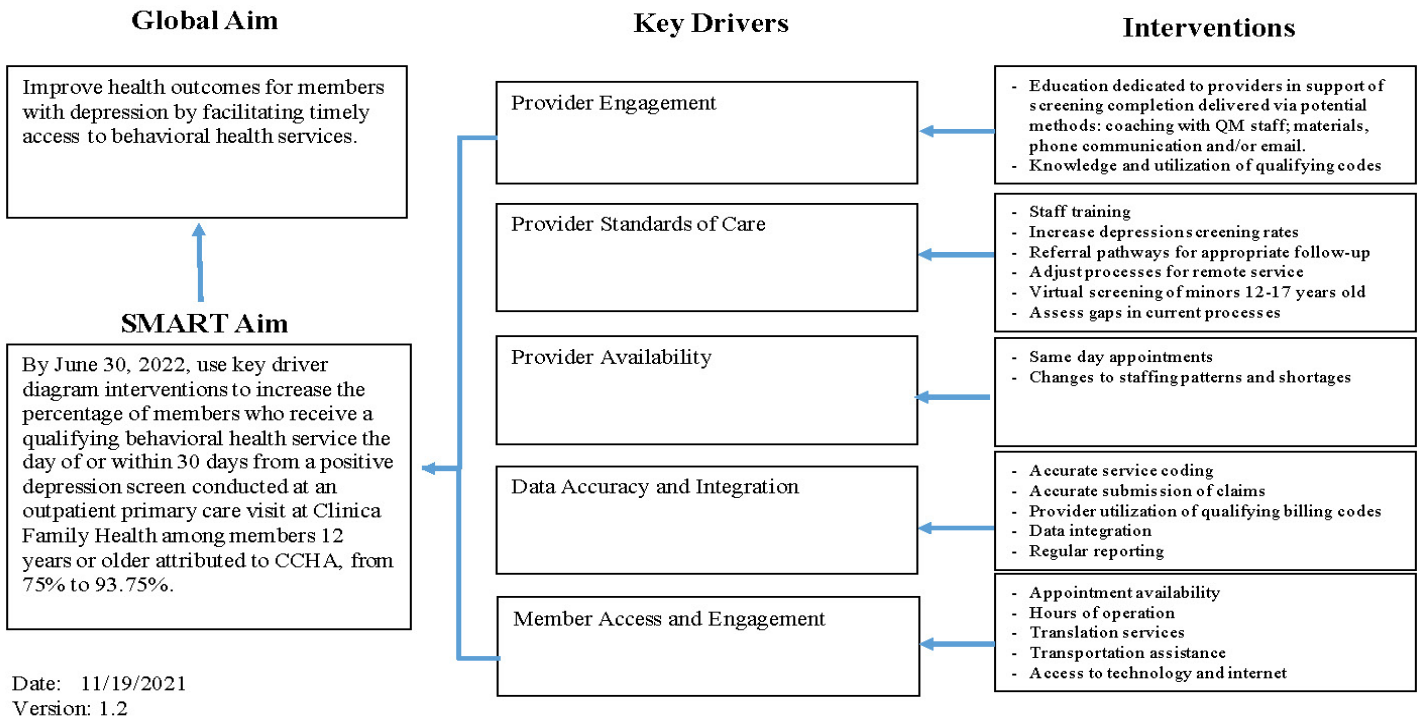
Key Driver Diagram – *Follow–up After a Positive Depression Screen*



Date: 11/19/2021
Version: 1.2

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Managed Care Organization (MCO) Information	
MCO Name	Colorado Community Health Alliance (CCHA) Regional Accountable Entity, Region 6
PIP Title	*Depression Screening and Follow–Up After a Positive Depression Screen*
Intervention Name:	Virtual screening of minors 12-17 years old at Clinica Family Health.
Contact Name	Camila Joao
Contact Title	Clinical Quality Program Manager
Email Address	Camila.Joao@cchacares.com
Telephone Number	720-612-6935
Submission Date	**6/25/2021**
Resubmission Date (if applicable)	**N/A**

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Intervention Testing Plan

Instructions:

- In Table 1, provide the specific details about the intervention including the intervention being tested; outcome (***Depression Screening*** or ***Follow–up After a Positive Depression Screen***), failure mode, and key driver addressed; step-by-step process to conduct the intervention test; and the predicted results.
- If the intervention was documented in the Module 2 submission form, use the same language to describe the key driver, failure mode, and intervention.
- If the intervention was not included the Module 2 submission form, the intervention should be added to the final key driver diagram in Module 4.

Table 1—Intervention Plan	
Intervention Being Tested	Virtual screening of minors 12-17 years old
Outcome Addressed	☒ *Depression Screening* ☐ *Follow–up After a Positive Depression Screen*
Failure Mode Addressed	Minors (12-17 years old) aren't screened for depression when mode of delivery is virtual.
Key Driver Addressed	Provider Standards of Care: Adjust processes for remote services.
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Identify virtual depression screening tool for minors 12-17 years old (PHQ-A) 2. Build electronic PHQ-A form for depression screening of members 12-17 years old receiving virtual services (GT modifier) 3. Integrate depression screening and documentation to virtual service workflow for members 12-17 years old 4. Procedure rollout and staff training

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Table 1—Intervention Plan	
	5. Develop internal tracking report to monitor depression screening that identifies the member's age, date of service, procedure code, provider, mode of delivery (virtual or in person), and completion of the Depression screening (G8510 and G8431). 6. Calculate and review rates monthly to provide training and/or adjust workflow as needed. (add additional steps as needed)

What are the predicted results of this test?	• Total number of unduplicated patients 12-17 years old seen for a virtual outpatient primary care appointment at Clinica during SFY21 (7/1/2020-5/31/2021): 466 members
	• Percentage of Depression Screenings administered in person to patients who are 12-17 years old during SFY21 (7/1/2020-5/31/2021): 58.62%
	• Predicted results: 50% of virtual primary care visits for patients 12-17 years old will have an electronic PHQ-9 screen administered by the end of the first quarter after implementation.
	  ○ Implementation: 7/1/2021
	  ○ Target date: 9/30/2021

Intervention Effectiveness Measure

Instructions:

- In Table 2, provide the intervention measure title, numerator description, and denominator description. This measure should specifically measure the intervention's effectiveness.
- In Table 3, complete the information for how data will be collected for the intervention test. If applicable, include a blank copy of the data collection tool (e.g., spreadsheets, tracking log).
- Refer to Section 5 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* ("Module 3—Intervention Testing").

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Table 2—Intervention Effectiveness Measure	
Intervention Measure Title	**(e.g., The number or percentage of eye exams scheduled on Saturday for Provider A)** Percentage of virtual depression screenings completed for minors 12-17 years old at Clinica.
Numerator Description	Total number of members 12-17 years old who received a depression screening (G8431 or G8510) during a virtual primary care service at Clinica.
Denominator Description	Total number of members 12-17 years old who attended a virtual outpatient primary care visit (GT modifier) at Clinica during the measurement period.

Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	Baseline determination: • Total number of unduplicated patients 12-17 years old seen for a virtual outpatient primary care appointment at Clinica during SFY21 (7/1/2020-5/31/2021): 466 members • Percentage of Depression Screenings administered in person to patients who are 12-17 years old during SFY21 (7/1/2020-5/31/2021): 58.62% Build internal tracking report for monthly review that identifies: 1. Number of patients who are 12-17 years old and received a virtual primary care service at Clinica each month (GT modifier). 2. Total number of patients 12-17 years old who received a Depression Screen during a virtual primary care service at Clinica (G8510 and G8431).
Describe the Data Sources	Clinica's Electronic Health Record and monthly Depression Screening report.

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Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe how Data will be Collected	1. Clinica staff will obtain/verify the patient's contact information at the time of scheduling. 2. Clinica's Electronic Health Record flags members 12 years old or older who need a depression screening as follows: - New members. - Existing members who turned 12 years old since the prior visit. - Members who have not received a Depression diagnosis in the 12 months prior to the visit. - Members with an existing Depression diagnosis. 3. At the time of the virtual appointment, members will receive a text message link to the electronic PHQ-A form to be filled out by the patient. 4. PHQ-A form will be automatically uploaded to the patient's chart in the EHR. 5. Medical Assistant (MA) and/or Providers will verify completion of the screening tool and score to determine course of action. 6. EHR automatically submits a claim for a positive or negative Depression screening (G8510, G8431 codes) when the screen is completed. 7. Provider will document the primary care service and mode of delivery in Electronic Health Record (EHR). 8. Clinica's Analytics team will pull a Depression Screening report monthly that includes the member's age, date of service, procedure code, provider, mode of delivery (virtual or in person), and completion of the Depression screening (G8510 and G8431). 9. Depression Screening report will be reviewed by PIP team monthly.
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	The Depression screening will be administered on the day of the service. Depression screening reports will be automatically pulled directly from the EHR and submitted to the PIP team monthly for review, to identify gaps, trends and address noted deficits in the process or in staff training.

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Managed Care Organization (MCO) Information	
MCO Name	Colorado Community Health Alliance (CCHA) Regional Accountable Entity, Region 6
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Intervention Name:	Behavioral Health Referral and Follow-up after a Positive Depression Screen.
Contact Name	Camila Joao
Contact Title	Clinical Quality Program Manager
Email Address	Camila.Joao@cchacares.com
Telephone Number	720-612-6935
Submission Date	**12/27/2021**
Resubmission Date (if applicable)	

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Intervention Testing Plan

Instructions:

- In Table 1, provide the specific details about the intervention including the intervention being tested; outcome (***Depression Screening*** or ***Follow–up After a Positive Depression Screen***), failure mode, and key driver addressed; step-by-step process to conduct the intervention test; and the predicted results.
- If the intervention was documented in the Module 2 submission form, use the same language to describe the key driver, failure mode, and intervention.
- If the intervention was not included the Module 2 submission form, the intervention should be added to the final key driver diagram in Module 4.

Table 1—Intervention Plan	
Intervention Being Tested	Behavioral Health Referral and Follow-up after a Positive Depression Screen.
Outcome Addressed	☐ *Depression Screening* ☒ *Follow–up After a Positive Depression Screen*
Failure Mode Addressed	Members with a positive depression screen aren't referred for additional behavioral health assessment/services.
Key Driver Addressed	Provider Standards of Care.
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Develop workflow for referring members with a positive depression screen for follow-up BH services. 2. Build report to verify that a BH referral occurred after a positive depression screen. 3. Build report to verify a BH service occurred within 30 days of a positive depression screen. 4. Provide a training refresher for staff to clarify expectations for follow-up after a positive depression screen. 5. Calculate and review rates monthly to provide training and/or adjust workflow as needed.

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Table 1—Intervention Plan	

What are the predicted results of this test?	• Total number of unduplicated patients 12+ years old who had a Positive Depression screen during September/2021: 83
	• Total number of unduplicated patients 12+ years old who received a virtual or in person BH service within 30 days of a positive depression screen: 47
	• Baseline follow-up rate: 56.63%
	• Predicted results:
	  ○ 73.49% of patients 12+ years old who have a positive depression screen will receive a follow-up BH service within 30 days from positive depression screen within 4 months from staff training.
	  ○ Training date: 12/1/2021
	  ○ Target date: 3/31/2022

Intervention Effectiveness Measure

Instructions:

- In Table 2, provide the intervention measure title, numerator description, and denominator description. This measure should specifically measure the intervention's effectiveness.
- In Table 3, complete the information for how data will be collected for the intervention test. If applicable, include a blank copy of the data collection tool (e.g., spreadsheets, tracking log).
- Refer to Section 5 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* ("Module 3—Intervention Testing").

Table 2—Intervention Effectiveness Measure	
Intervention Measure Title	**(e.g., The number or percentage of eye exams scheduled on Saturday for Provider A)**
	Behavioral Health Referral and Follow-up after a Positive Depression Screen.

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Table 2—Intervention Effectiveness Measure	
Numerator Description	Total number of members 12 years or older who received a referral and BH service at Clinica within 30 days from a positive depression screen.
Denominator Description	Total number of members 12 years or older who had a positive depression screen within the measurement period at Clinica.

Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	Baseline determination: • Total number of unduplicated patients 12 years or older who received had a positive depression screen during the baseline measurement period (9/1/2021-9/30/2021): 83 • Percentage of members who received a BH follow-up service at Clinica within 30 days from a Positive Depression Screen: 66 Build internal tracking report for monthly review that identifies: 1. Number of patients who are 12 years or older who have a Positive Depression Screen (G8431) each month. 2. Number of patients 12 years or older who receive a BH follow-up service at Clinica within 30 days from a Positive Depression Screen.
Describe the Data Sources	Clinica's Electronic Health Record and monthly Referral/Follow-up after a Positive Depression Screen report.
Describe how Data will be Collected	1. Clinica's Electronic Health Record flags members 12 years old or older who need a depression screening as follows: - New members. - Existing members who turned 12 years old since the prior visit.

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Table 3—Intervention Effectiveness Measure Data Collection Process	
	- Members who have not received a Depression screen in the 12 months prior to the visit. - Members with an existing Depression diagnosis. - Members who were eligible and refused a Depression screen during the prior visit. 2. At the time of service (in person or virtual), Clinica staff will administer Depression screens for flagged members. 3. Medical Assistant (MA) and/or Providers will verify completion of the screening tool and score to determine course of action. 4. Medical Assistance (MA) will enter a referral to Clinica BHP follow-up in the EHR. 5. Member's EHR chart will display an alert for "positive depression screen requiring BH f/u". 6. Clinica BHP staff will outreach member the day of service/screen to provide follow-up BH service. 7. Clinica's Analytics team will pull a Referral/BH Follow-up report monthly that includes the number of members who received a positive screen, and the number of members who receive a BH service within 30 days of positive screen. 8. Referral/BH Follow-up report will be reviewed by PIP team monthly.
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	The Depression screening will be administered on the day of the service for qualifying members based on aforementioned criteria. Members with a Positive Depression Screen will receive a referral for BH follow-up services. Clinica's BHP staff will outreach member for follow-up BH service within 30 days from screen. Referrals and BH Follow-up service reports will be automatically pulled directly from the EHR and submitted to the PIP team monthly for review, to identify gaps, trends and address noted deficits in the process or in staff training.

Appendix B. Module Validation Tools

Appendix B contains the Module Validation Tools provided by HSAG.

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Criteria	Score	HSAG Feedback and Recommendations
1. The MCO included process maps for *Depression Screening* and *Follow–up After a Positive Depression Screen* that clearly illustrate the step-by-step flow of the current processes for the narrowed focus.	☒ Met ☐ Not Met	
2. The prioritized steps in the process maps identified as gaps or opportunities for improvement were highlighted in yellow.	☒ Met ☐ Not Met	
3. The steps documented in each FMEA table aligned with the steps in the corresponding process map that were highlighted in yellow as gaps or opportunities for improvement.	☒ Met ☐ Not Met	
4. The failure modes, failure causes, and failure effects were logically linked to the steps in each FMEA table.	☒ Met ☐ Not Met	
5. The MCO prioritized the listed failure modes and ranked them from highest to lowest in each Failure Mode Priority Ranking table.	☒ Met ☐ Not Met	
6. The key drivers and interventions in each key driver diagram were updated according to the results of the corresponding process map and FMEA. In each key driver diagram, the MCO included interventions that were culturally and linguistically appropriate and have the potential for impacting the SMART Aim goal.	☒ Met ☐ Not Met	

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Criteria	Score	HSAG Feedback and Recommendations
Additional Recommendations: None.		

Intervention Determination (Module 2)

☒ Pass

Date: May 12, 2021

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for **Colorado Community Health Alliance –RAE 6**

Intervention: Virtual Screening of Minors 12–17 Years Old at Clinica Family Health

Criteria	Score	HSAG Feedback and Recommendations
1. The Intervention Plan specified the outcome to be addressed and included at least one corresponding key driver and one failure mode from Module 2.	☒ Met ☐ Not Met	**General Comment:** The health plan should add the specific intervention description, "Virtual screening of minors 12-17 years old," to the final *Depression Screening* key driver diagram (KDD) that will be included in Module 4 at the end of the project. The final KDD should include the specific interventions tested for the PIP.
2. The MCO included all components for the Intervention Plan.	☒ Met ☐ Not Met	
3. The *Intervention Effectiveness Measure(s)* was appropriate for the intervention.	☒ Met ☐ Not Met	
4. The data collection process was appropriate for the intervention effectiveness measure(s) and addressed data completeness.	☒ Met ☐ Not Met	
Additional Recommendations: None.		

Intervention Testing (Module 3)

☒ Pass

Date: July 20, 2021

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Intervention: Behavioral Health Referral and Follow-up After a Positive Depression Screen

Criteria	Score	HSAG Feedback and Recommendations
1. The Intervention Plan specified the outcome to be addressed and included at least one corresponding key driver and one failure mode from Module 2.	☒ Met ☐ Not Met	
2. The MCO included all components for the Intervention Plan.	☒ Met ☐ Not Met	
3. The *Intervention Effectiveness Measure(s)* was appropriate for the intervention.	☒ Met ☐ Not Met	
4. The data collection process was appropriate for the intervention effectiveness measure(s) and addressed data completeness.	☒ Met ☐ Not Met	
Additional Recommendations: • If possible, the health plan may want to track the percentage of staff/providers at Clinica who received the workflow training and/or record any qualitative feedback from training attendees, as additional sources of information on intervention effectiveness. Qualitative attendee feedback may help to improve future training efforts. Being aware of the percentage of staff who attended the training will provide a measure of intervention reach and help inform interpretation of the defined intervention effectiveness measure.		

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Criteria	Score	HSAG Feedback and Recommendations
• In addition to the defined intervention effectiveness measure, which tracks percentage of members with a positive depression screen who receive behavioral health (BH) service within 30 days (intervention process step 3), the health plan may consider adding an additional effectiveness measure to track the percentage of members who screen positive and received a referral for BH service (intervention process step 2). This additional measure may provide a more complete picture of effectiveness and impact, helping to determine if additional process flaws exist between providing a referral and completing follow-up BH service.		

Intervention Testing (Module 3)

☒ Pass

Date: January 21, 2022